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ABSTRACT

This report describes a collaborative study undertaken by 72 psychoanalysts in an effort to (1) collect systematic data about obese patients in psychoanalysis and (2) assess the effect of psychoanalysis in the treatment of obesity. A total of 84 obese and 63 normal weight patients was studied. Each analyst completed a detailed questionnaire on his patients. A few of the main findings follow. Obesity was the chief complaint for only 6% of the obese patients. However, their weight loss compared favorably to those achieved with traditional medical efforts: 55% lost more than 20 pounds and 18% more than 40. traditional medical efforts: 55% lost more than 20 pounds and 18% more than 40. In addition, treatment was associated with a significant lessening of body image disparagement. Confirming other reports, obese patients were reported to be significantly less active than normal weight patients and a strong familial aggregation of obesity was described. Disturbed eating patterns were found with significantly greater frequency among obese patients. (Author)

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OBESITY AND PSYCHOANALYSIS*

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Most obese adults would like to be slimmer. Unfortunately, whether they pay-to-lose or attempt to lose weight without supervision, the vast majority will remain obese. In order to better understand the problem, many obese populations have been studied : obese juveniles (e.g. Hunemann et. al, 1974; Mayer, 1968), moderately overweight college students (e.g. Nisbet & Storms, 1974; Schacter, 1968), massively obese adults (e.g. Hirsh, 1973; Chandler, 1974); normal weight adults who voluntarily became obese for research purposes (e.g. Sims et. al, 1973), and obese adults participating in a variety of treatment programs (see Kiell, 1973).

The present investigation examines a sample of obese patients in treatment by psychoanalysts. Except for Burch (1973), most descriptions of obese patients in psychoanalysis are based on a few case reports (see Kaplan & Kaplan, 1957). Not only may obese adults in psychoanalysis represent a different population from that usually studied, but psychoanalysts have a greater exposure to patients than most other therapists. Specifically, the purposes of this study were to: (1) determine the feasibility of studying patients in treatment by psychoanalysts; (2) collect systematic data on patients previously only anecdotally described; and (3) assess the effectiveness of psychoanalysis in mitigating the obese condition.

The Questionnaire

Seventy-two psychoanalysts, who were members of the American Academy of Psychoanalysis, participated in this study. Each psychoanalyst was asked to fill out a questionnaire on both an obese and a normal weight patient, matched for sex, race, and approximate age. An obese patient was defined as someone who "looked fat" and who was at least 15-20% overweight at the start of treatment.

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The obesity questionnaire included 61 multiple-choice items. Major areas included weight reduction and weight gain, body image disparagement, eating practices, and childhood history.

The Obesity Questionnaire was constructed to be answered by psychoanalysts about patients they were seeing in therapy, not by the patients themselves. Although analysts were free to show the questionnaire to their patients, many did not. Many questions relied on the clinical judgement of the psychoanalyst, and were intended to utilize the very intimate and extensive knowledge and insight the analyst had about his patient.

The Sample

The sample consisted of 147 patients: 64 obese women, 46 normal weight women, 20 obese man, and 17 normal weight men. Patients were fairly representative of patients in individual psychoanalysis or psychotherapy (e.g. Weber et al, 1967). They were middle class, well educated adults. Approximately half were Jewish, with the remainder being Protestant or Catholic. The obese and normal weight patients were statistically comparable on these variables.

Weights of obese and normal weight patients were markedly different. Not only were the obese patients clearly overweight, but the normal weight patients were somewhat slimmer than average. Obese women averaged 197 pounds, normal weight women, 119 pounds ($t=12.074$, 86 df, $p \leq .001$), and obese men averaged 247 pounds, normal weight men, 157 pounds ($t=7.579$, 30 df, $p \leq .001$).

Psychopathology

Obese patients did not seek psychiatric treatment because of their obesity. Weight was reported to be the chief complaint for only 6% of the obese patients. The majority (60%) of both obese and normal weight patients were reported to be depressed and/or anxious (see Weber et al, ibid). Relatively small differences in psychopathology between obese and nonobese adults have also been documented by Stunkard (1975). About half of both the obese and the normal weight patients had been in treatment longer than three years.

RESULTS

Data on patients are discussed in two sections: (1) characteristics of obese patients and (2) weight change during treatment. Missing data occured throughout the questionnaire. Percentages reported for each item are based on adusted sample sizes.

1. Characteristics of Obese patients

Acceptance of Stigma

Socio-cultural attitudes are both more negative and more uniform towards obesity than other variations in appearance (e.g. Monello & Mayer, 1963; Richardson et. al, 1961). In this sample, the majority of both obese (64%) and normal weight (63%) patients were reported to disapprove of obesity.

Most obese patients were reported to apply the cultural stigma assigned to obesity to themselves. As illustrated in Figure 1, significantly more obese than normal weight patients were reported to consider themselves unattractive ($X^2 = 40.237$, 5 df, $p \leq .001$) and made frequent derogatory remarks about their appearance ($X^2 = 37.501$, 2 df, $p \leq .001$).

The difference between obese and normal weight patients in evaluation of their appearance is dramatic, and contrasts with the finding of minimal differences in reported psychopathology.

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Insert Figure 1 About Here

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Treatment by psychoanalysts effectively reduced the intensity of body image disparagement. Of the patients with mild or severe body image disparagement at the start of treatment, approximately 40% of both the obese and normal weight patients were reported to feel more positive about their physical appearance currently. This is particularly impressive, since body image disparagement persists without treatment (Stunkard & Mendelson, 1967). (Note: 11% of the patients were reported to express greater disparagement at the time the questionnaire was completed).

Weight Maintaining Behaviors

In order to maintain excessive weight, obese people must eat more and/or exercise less than normal weight individuals (e.g. Beaudine & Mayer, 1951; Stunkard & Pestka, 1962). When they limit their caloric intake or increase their daily exercise, most obese people lose weight (e.g. Miller and Parsonage, 1975; Gwinup, 1975). Each of the four weight maintaining behaviors we examined revealed large differences between obese and normal weight patients.

Between Meal Eatin Patterns

Stunkard (1959) identified two eating patterns frequently associated with obesity: night eating and binge eating. Nibbling, a third pattern, has also been associated with obesity (e.g. Beaudoin & Mayer, ibid.). Incidence of the patterns is not well documented (compare Stunkard, 1959, to Bruch, 1973). For purposes of the questionnaire, the patterns were defined as follows:

Night-eating: Night-eating occurs when a person eats 25% or more of his daily intake in the evening, coinciding with a usual schedule (day-activity, night-sleep).

Binge-eating Binge-eating occurs when a person consumes food rapidly with a sense of loss of control.

Nibbling: Nibbling occurs when a person "finds" or gets things to eat apart from meals or regular snacks (e.g. an established coffee break).

Dramatically more obese than normal weight patients were reported to eat between meals. Eighty-one out of 82 obese patients were reported to have exhibited at least one of the three eating patterns, whereas fewer than half (42%) of the normal weight patients had (X^2= 51.86, 1 df, $p \leq .001$). Figure 2 presents the data for obese and normal weight patients exhibiting all or none of the eating patterns.

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Eating Under Stress

Many obese adults say that they eat when they are worried or upset. If they do in fact significantly increase their intake when stressed, this should be reflected in weight gain. A major weight gain of 10 or more pounds during periods of obvious life stress (e.g. marriage, death, divorce, occupational change) was reported for 79% of obese compared to 9% of normal weight patients (X^2= 60.473, 1 df, $p \leq .001$).

It is interesting that 63 out of 64 patients who were reported to have gained 10 or more pounds during periods of life stress were also reported to eat between meals when under stress. It is probable that the between meal eating is directly responsible for weight gain at such times.

Food Cravings and Aversions

Taste of food has been shown to effect the behaviors of obese and normal weight animals (e.g. Nisbett, 1972) and people (e.g. Wooley & Wooley, 1975). Presence of food cravings and aversions is one index of the effect of taste, and one intuitively related to food consumption. In this sample, presence of food cravings but not food aversions distinguished obese from normal weight patients. Food cravings were reported for 47% of the obese compared to 17% of the normal weight patients (X^2 = 12.108, 1 df, $p \leq .001$). Failure to find significant differences in food aversions between normal and overweight adults (college students) was also reported by Garb & Stunkard (1974).

Exercise

Inactivity can have two potential effects on obesity: it can contribute to its perpetuation and it may also influence its development (e.g. Bullen, Reed & Mayer, 1964; Chirico & Stunkard, 1960; Mayer, 1969). Psychoanalysts were asked to specify, on the following three point scale, how much physical exercise patients did on a weekly basis:

1. None: no regular exercise; rides rather than walks.
2. Some: at least once a week: plays tennis, golf, swims, jogs, bikes etc.
3. A lot: three or more times weekly: plays tennis, golf, swims, jogs, bikes, etc. Prefers stairs to elevators.

Obese patients were reported to be far less active than normal weight patients (X^2= 15.375, 2 df, $p \leq .001$), as illustrated in Figure 2, above. The majority (70%) of obese patients did no regular exercise whereas the majority of normal weight patients did.

Childhood History

Development of obesity reflects a complex interplay between heredity and environment: it has been called a "geneticist's nightmare" (Hunt, 1972). Not only must a person have the capacity to routinely over eat (genetic endowment) but he must have a surplus of food available to him (environment). Our data suggest the presence of both factors.

The large majority of obese patients in our sample had a long history of obesity: 84% were obese prior to adulthood compared to 5% of the normal weight patients (X^2= 118.235, 4 df, $p \leq .001$); see Figure 3, below.

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Heredity

Significantly more parents of obese than normal weight patients were reported to be obese (X^2= 11.806, 1 df, $p \leq .001$), as illustrated in Figure 3, above. Incidence of obesity in siblings was also more frequently reported for obese patients: 32% of obese compared to 14% of normal weight patients were reported to have obese siblings (X^2= 4.650, 1 df, $p \leq .05$). These data are comparable to those reported for other patient samples (e.g. Mullins, 1957; Withers, 1964).

Food History

More obese than normal weight patients were reported to have had unusual food experiences while growing up. Significantly more obese than normal weight patients were reported to have been given too much to eat (X^2= 22.978, 2 df, $p \leq .001$), to have been given food as a reward for good behavior (X^2= 12.443, 3 df, $p \leq .006$), and to have had bizarre eating habits as children (e.g. eating very fast, eating large amounts of unusual items; X^2= 4.289, 1 df, $p \leq .038$).

2. Weight Change During Treatment

The majority of obese patients (64%) lost weight during treatment even though weight loss was not a primary treatment goal. Twenty-eight percent lost more than 20 pounds, and 9% more than 40 pounds; see Figure 4. This compares favorably to weight loss of patients entering general outpatient clinics specifically to lose weight (Stunkard & McLaren-Hume, 1959). Of the remaining obese patients, 20% showed no change in weight and 16% gained weight. No normal weight patient lost or gained more than

ten pounds. Differences between obese and normal weight patients in amount of weight lost (X^2= 32.145, 6 df, $p \leq .001$) and weight gained (X^2= 11.914, 4 df, $p \leq .018$) are significant.

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Insert Figure 4 About Here

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Age of Onset of Obesity and Sex

In this sample, patients with juvenile onset of obesity lost as much weight as patients with adult onset, and women lost as much weight as men. Similar results were reported by Gwinup (1975) and Wing & Jeffery (1976), and contrast with results of earlier studies (e.g. Mullins, 1958; Stunkard & McLaren-Hume, 1959).

COMMENT

This study was designed to assess the possibility of obtaining systematic data on patients in treatment by psychoanalysts, to investigate factors that might discriminate obese from normal weight patients, and to determine if treatment by psychoanalysis were associated with weight loss of obese patients.

Feasibility. Seventy-two psychoanalysts participated in this study. Each was asked to fill out a lengthly questionnaire on both an obese and a normal weight patient. That 147 completed questionnaires were returned attests to the feasibility of this method. However, not only did most psychoanalysts require several months to complete the questionnaires but several follow-up communications requesting return of the questionnaires were often required.

Three other studies involving large numbers of patients in treatment by psychoanalysts have been conducted (Bieber et al., 1962; Hamburg et al., 1967; Weber et al., 1967). This study is unique in focusing on a psycho-somatic complaint. Although questionnaire studies are time consuming, the quality and kinds of data obtained suggest that surveys of patients in treatment by psychoanalysts are important to our understanding of psychiatric illnesses.

Characteristics. There was great variability within obese subjects. Weight related attributes, however, did distinguish them from normal weight patients.

Briefly, the distinguishing psychological characteristic of obese patients was disparagement of their physical appearance. Weight maintaining behaviors included eating between meals, eating under stress, craving particular foods, and leading a sedentary life. Factors contributing to the development of adult obesity included having obese parents, being obese during childhood, and having unusual food experiences while growing up.

This study also yielded a composite picture typical of more normal weight than obese patients. Reported attributes of normal weight patients included: getting regular exercise, accepting their physical appearance, eating primarily at meals with occasional nibbling, having normal weight parents, and having uneventful childhood food histories.

Because parents can largely control what and how much their children eat, especially when children are young, it can be presumed that some parents of obese patients permitted their obesity to develop. Failure to actively supervise food intake of a stocky child who likes to eat can only increase the probability that obesity will result.

Treatment. Most obese patients did not enter psychoanalysis specifically to lose weight, and only one psychoanalyst reported active supervision of weight loss. This may be in part because the "demand characteristics" of going to a psychiatrist are such that attention usually focuses on emotional problems. Nevertheless, patient weight loss occuring in conjunction with psychotherapy compares favorably to that of patients in traditional general out-patient clinic programs where weight loss is the specific treatment goal (e.g. Stunkard & McLaren-Hume, 1959).

Psychoanalytic treatment was also associated with a marked decrease in the incidence of severe body image disparagement by both obese and normal weight patients. Evidently, in the process of working through unresolved emotional conflicts, many patients become more accepting of their physical appearance.

Prognosis. What is the prognosis for patients succesfully maintaining their weight loss after treatment is terminated? Most patients in this study are still in therapy. We would predict, however, that after treatment is terminated patients will tend to maintain weight loss so long as their lives are emotionally manageable. This prediction is based on the following reasoning: (1). For many obese patients, obesity symbolizes underlying emotional disturbances; (2). If formerly obese patients do not maintain their emotional well-being, their symptom (obesity) will return. We would also speculate that those patients who seek treatment during periods of emotional stress will be better able to maintain weight loss than those who do not.

Maintaining weight loss requires continuing personal motivation to regulate food intake: the knowledge that eating chocolate once symbolized obtaining love and now satisfactorily obtaining love elsewhere may not affect the desire to eat chocolates because they taste good. If personal motivation lags, the probability of weight gain increases.

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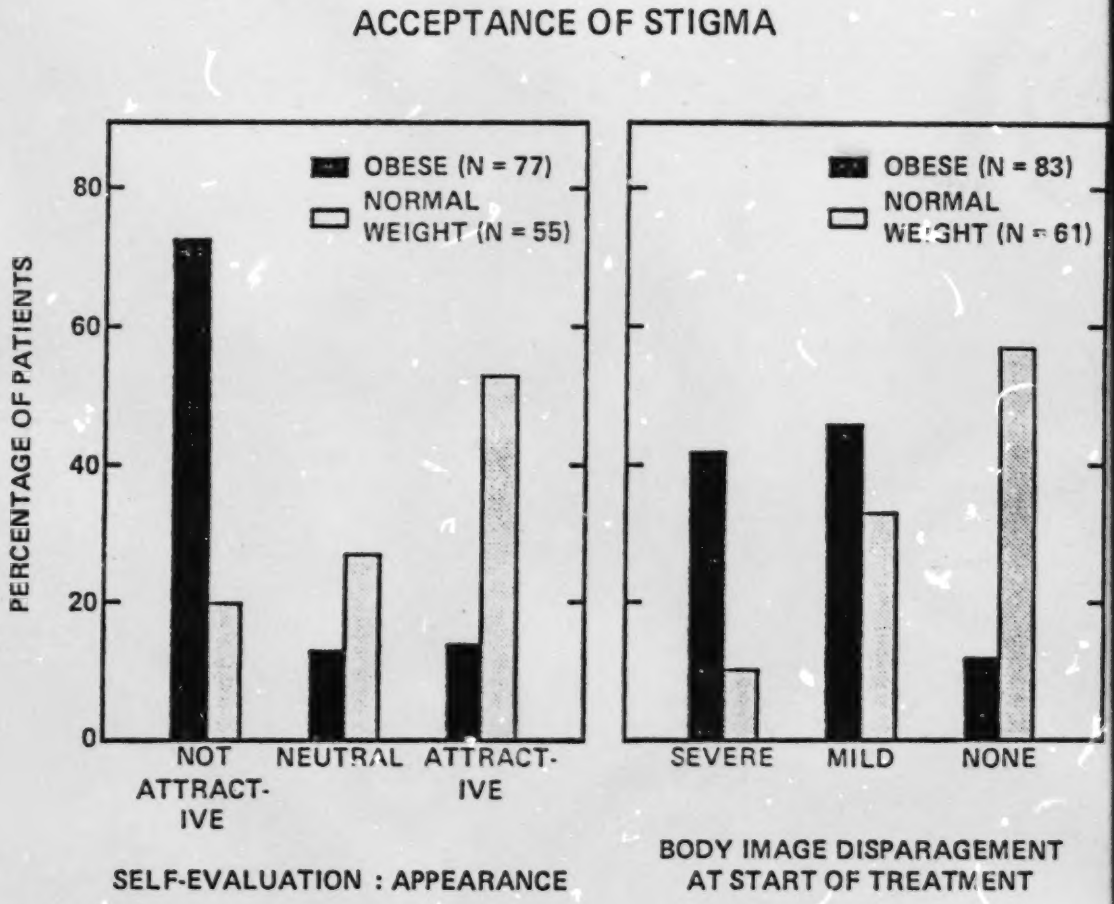
Fig. 1


ACCEPTANCE OF STIGMA
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60
40
20
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NORMAL WEIGHT (N = 55)
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NEUTRAL
ATTRACT-IVE
SELF-EVALUATION : APPEARANCE
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NORMAL WEIGHT (N = 61)
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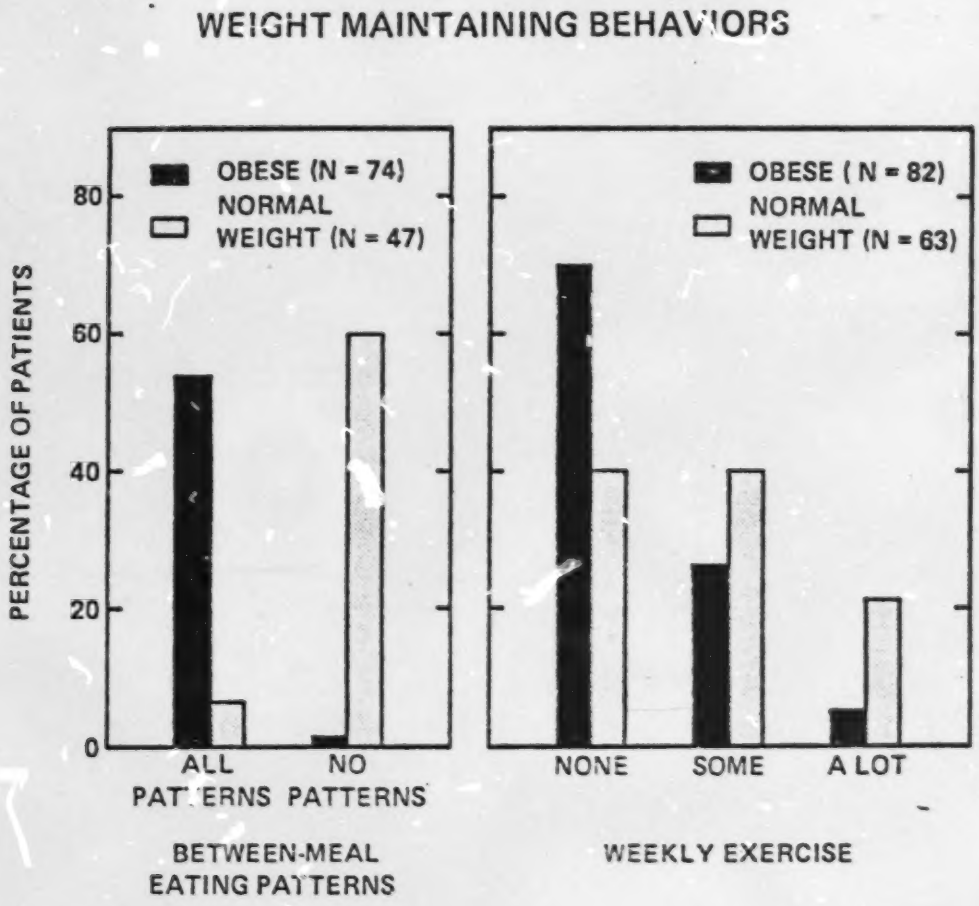
MILD
NONE
BODY IMAGE DISPARAGEMENT AT START OF TREATMENT

Fig. 2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NORMAL WEIGHT (N = 47)
OBESE (N = 82)
NORMAL WEIGHT (N = 63)
PERCENTAGE OF PATIENTS
80
60
40
20
0
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NO PATTERNS
NONE
SOME
A LOT
BETWEEN-MEAL EATING PATTERNS
WEEKLY EXERCISE

CHILDHOOD HISTORY

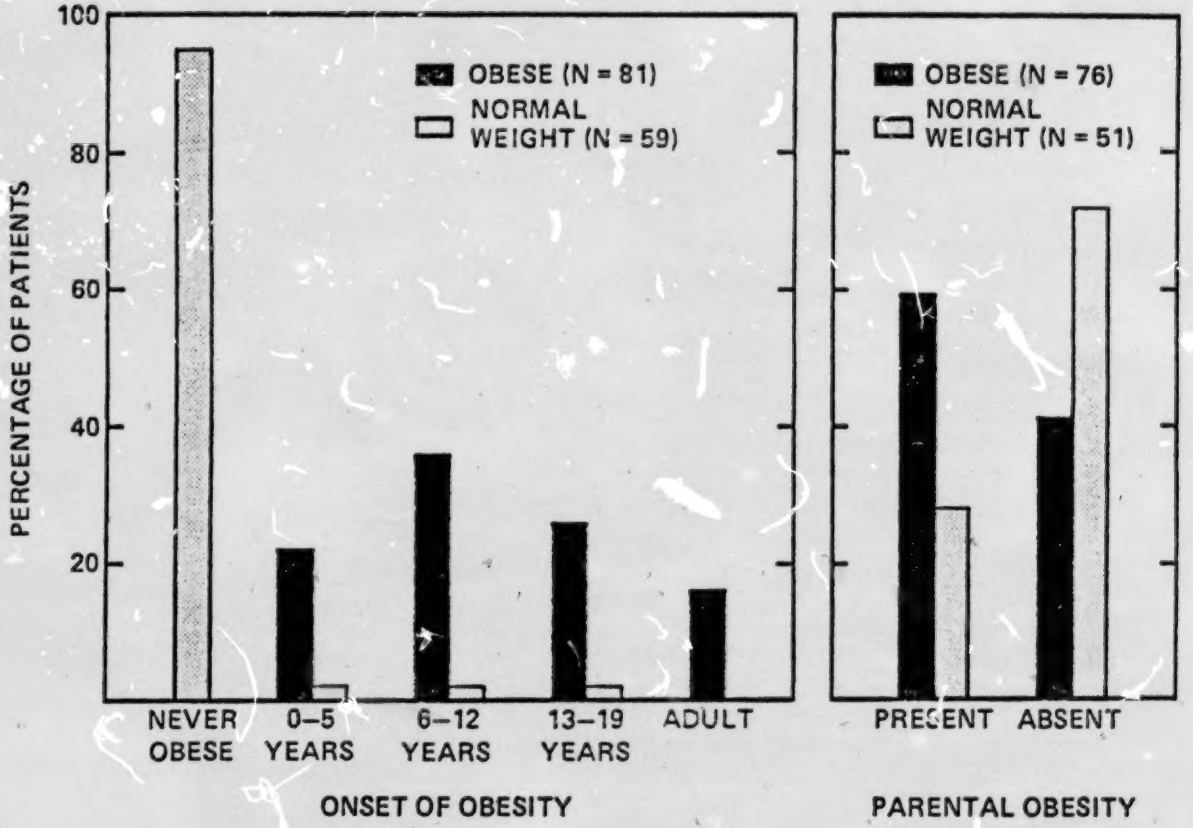

Fig. 3

Fig. 4

WEIGHT REDUCTION DURING THERAPY